The Health Care Quality Improvement Act and Physician Peer Review: Ingredients for Effective Dispute Resolution

I. INTRODUCTION

Physician peer review committees have existed for at least ten years, but they have not been completely effective in policing their physician colleagues.[1] Physician peer review committees are committees within hospitals that are responsible for the discipline of physicians who abuse their staff privileges, disregard hospital bylaws, or engage in conduct which could potentially endanger the welfare of patients. The members of these committees are physicians who themselves have privileges within the hospital and, in most cases, serve on a voluntary basis. The ultimate goal of the committee is to monitor all physicians and ensure high quality health care. If the committee finds that a physician's acts are egregious, the committee has the authority to withdraw the physician's staff privileges. Without staff privileges, the physician no longer has permission to use the hospital's facilities. The committee also has an obligation to report its actions to the state licensing board which may decide, if warranted, to revoke the physician's license. Without a license, the physician can no longer practice medicine in that state.

The peer review process seeks to prevent the substandard activity which often leads patients who have suffered an injury at the hands of their physician to file suit. Physician peer review committees can be a powerful tool in identifying the incompetent physician and need to be utilized to that end. Through the preventive actions of these committees, the potential for litigation is markedly reduced. This Note will include in its discussion the Oregon case that threatened the future of peer review, the federal legislation that provides peer review committees with immunity, and actions taken on the state level to protect physicians who serve on peer review committees.

II. *PATRICK V. BURGET*

In December 1984, the jury found in favor of the plaintiff, Dr. Timothy Patrick in his suit against the members of an Oregon peer re-

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1. For a history of peer review, see Haines, *Hospital Peer Review Systems: An Overview*, 2 HEALTH MATRIX 4, 30 (1984-85); Comment, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1116-18 (1988); Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552, 554-65 (1979).

view committee for violation of Sections 1 and 2 of the Sherman Antitrust Act.[2] The court held that the defendant physicians had illegally conspired to restrict Dr. Patrick's opportunity to practice. The Oregon jury awarded him $650,000 in damages, which, under antitrust law was trebled to $1.95 million. In addition, he received $20,000 in compensatory damages, $90,000 in punitive damages, and $228,600 in attorney's fees. The total award reached $2.3 million.[3]

The history of this case dates back to 1972, when Dr. Patrick, a general surgeon, went to Astoria, Oregon, a small city of 10,000 people, to join the Astoria Clinic. Physicians in the area, including those at the Clinic, had privileges at Columbia Memorial Hospital, Astoria's only hospital. After completing a one year probationary term, Dr. Patrick was offered the opportunity to become a partner at the Clinic. Displeased with his income, Dr. Patrick refused the offer and started his own clinic in Astoria.[4]

In the ten years that followed, Dr. Patrick received no surgical referrals from the Clinic, despite being the only surgeon at the local hospital. The physicians from Astoria Clinic would refer patients to hospitals fifty miles away rather than to Dr. Patrick. When he did treat patients from the Astoria Clinic, he was accused by the Clinic doctors of stealing their patients. The doctors at the Clinic refused to give their medical opinion concerning Dr. Patrick's patients, yet, at the same time, criticized him for failure to get outside consultations.[5]

In 1981, the Columbia Memorial Hospital staff peer review committee began the process of terminating Dr. Patrick's privileges at the urging of

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2. Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986). The Sherman Antitrust Act is codified at 15 U.S.C. §§ 1-7. The jury in *Patrick* found that Sections 1 and 2 had been violated which read as follows:

§ 1. Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

§ 2. Monopolizing trade a felony; penalty

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

3. Patrick v. Burget, 800 F.2d 1498, 1505.

4. *Id.* at 1502.

5. *Id.*

Dr. Harris, an Astoria Clinic physician. The committee voted to withdraw Dr. Patrick's privileges because they felt that his care of patients had been substandard.[6] Patrick presented a defense at his hearing, but the audience of physicians seemed disinterested in what he had to say. Sensing unfair bias against him by the committee, Dr. Patrick voluntarily resigned before the hospital reached its decision.[7] A neighboring hospital immediately welcomed him and gave him hospital privileges.

Subsequently, Dr. Patrick filed suit against the doctors of the Astoria Clinic for alleged violations of Sections 1 and 2 of the Sherman Act.[8] The jury found that the termination of Patrick's privileges by the Columbia Memorial Hospital violated the antitrust act and awarded the aforementioned damages.[9]

The result of this case stunned physicians, hospitals, and their peer review committees.[10] Could it be that by participating in the evaluation of their fellow physicians, to rid the profession of the few who engaged in malpractice, members of peer review committees were potentially liable in a federal antitrust suit?

III. The Health Care Quality Improvement Act of 1986

The *Patrick* case was the impetus behind Representative Ron Wyden's drafting of the Health Care Quality Improvement Act [hereinafter HCQIA or the "Act"] which became part of an omnibus health bill passed by Congress and signed into law by President Reagan on Novem-

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6. The committee's decision to revoke Dr. Patrick's privileges was based on 21 cases. Some of those cases were handled by a physician other than Dr. Patrick, but were used in his evaluation for some unexplained reason.

7. Patrick v. Burget, 800 F.2d 1498, 1504. The chairman of the committee that heard the case was Dr. Boelling, an Astoria Clinic physician who had presented charges against Dr. Patrick to the Oregon Board of Medical Examiners two years earlier.

8. *Id.*

9. *Id.* at 1505.

10. General counsel for the American Medical Association (AMA), Kirk Johnson, indicated that the AMA was in disagreement with the outcome of *Patrick* and thought that it "could have a chilling effect on peer review." Holthaus, *The Patrick Case: Will It Hinder Peer Review?*, 1988 Hosp. 56, 56. The director of medical/legal affairs for the Oregon Medical Association, Paul R. Frisch, stated that "[t]he Supreme Court's decision in Patrick v. Burget left peer reviewers with a tremendous sense of discouragement." 13 Hosp. Peer Rev. 93 (1988). "The trial court decision in the case *Patrick v. Burget*, was widely cited in medical society journals and caused near panic in the medical community since it assessed damages against peer review board members for violation of the Sherman Act as well as for state law claims." Braveman & Kough, *Peer Review Liability: Guidelines for Advising Physician Clients*, 11 L.A. Law. 43, 43-44 (1988).

ber 14, 1986.[11] Wyden sees the HCQIA as "the first step toward a national malpractice strategy."[12] The purpose of the Act is twofold: first, it encourages good faith peer review by physicians serving on hospital review committees; and second, it creates a national practitioner data bank that will receive reports from the state medical boards regarding medical malpractice suits and revocation of clinical privileges.[13]

It is hoped that Representative Wyden's legislation will help ameliorate the medical malpractice crisis by facilitating open and honest peer review.[14] The various methods used previously by the states have been unsuccessful, prompting the Committee on Energy and Commerce to vocalize its concern that the self-regulation of the medical profession is not as effective as is necessary to rid the field of inept doctors.[15]

Much of the blame for the inadequacy of the system must fall upon the hospitals.[16] It is customary hospital practice to allow those physicians who are negligent, or fail to meet the hospital bylaws, to voluntarily resign with a clean record rather than to dismiss them with bad marks. With this veil of secrecy, incompetent physicians are able to begin practice in another state free from any adverse consequences or damage to their reputation.[17] Of the 450,000 practicing physicians in the United States, three to five percent, or 18,000 doctors, are not competent in their current status as practitioners administering treatment to trusting patients.[18]

With this prevalence of incompetency, one would expect that competition and pressure from others in the profession would force the impaired physician out of business. But evidence proves that this is not the case.

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11. The Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3794 (1986) (codified at 42 U.S.C. §§ 11101-11152) (amended by the Public Health Service Amendments of 1987, Pub. L. No. 100-177, 101 Stat. 986 (1986)).

12. 141 CONG. REC. H9963 (daily ed. Oct. 14, 1986).

13. H.R. REP. No. 903, 99th Cong., 2d Sess. 3, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384.

14. In order to remedy the recent surge in medical malpractice claims, new systems are needed to "encourage these doctors to bring cases of incompetence to disciplinary authorities." Rep. Wyden in support of his Bill, 141 CONG. REC. H9963 (1986).

15. *See supra* note 13, at 6385.

16. In the past, the malpracticing physician has rarely had his license revoked by the state medical board because it was seldom aware of any disciplinary actions taken by the hospitals. Most states mandate that hospitals and physicians report actions of incompetence (and thus discipline) to the state medical board, yet few have done so. *See* Bierig & Portman, *The Health Care Quality Improvement Act of 1986*, 32 ST. LOUIS U.L.J. 977, 980-81 (1988).

17. *See supra* note 13, at 6385. There are numerous reports to show that physicians do move from state to state. *See* Comment, *Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May be Worse Than the Disease*, 37 CATH. U.L. REV. 1073, 1074 n.11 (1988).

18. 141 CONG. REC. H9964 (1986).

Why would a seemingly reputable and distinguished profession such as medicine permit inept individuals to continue practicing unchallenged? For an answer to this question, one must consider what is at stake for the physician who suspects a peer is not meeting the profession's standards and reports this malfeasance to the peer evaluation committee. If the committee takes disciplinary action but the suspicion is unfounded, then the accused peer can retaliate in an antitrust suit against the members of the committee potentially resulting in substantial money damages. That this is possible is demonstrated by the *Patrick* case. There is no incentive for a physician to serve on a peer review board when the risks of liability are so great.[19] With the passage of the HCQIA, hospitals, through their peer review boards, can take steps to eliminate malpracticing physicians without incurring risk of antitrust liability.

Subchapter I of the HCQIA contains its protective provisions and provides immunity to physicians and dentists who serve on professional review committees associated with hospitals and other health care entities that follow a "formal peer review process for the purpose of furthering quality health care."[20] Physicians and dentists are granted immunity from suits for damages under either federal (i.e. antitrust) or state law.[21] Immunity is also extended to state licensing boards. There is a limit to the immunity, however, as it does not apply to actions under the Civil Rights Acts or to those actions brought by state attorneys general.[22]

In order to receive the Act's protection, professional review boards must take action "in the reasonable belief that the action was in furtherance of quality health care" and after a reasonable effort to obtain the

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19. "Doctors participating in peer review face the tremendous risk these days that they will be sued for their actions against a colleague." Rep. Wyden in support of his Bill, 141 CONG. REC. H9963 (1986). Twenty-one percent of the physicians who have recently participated in peer review have experienced a decreased number of referrals and even ridicule from their peers. Comment, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1120 (1988)(citing survey discussed in Owens, *Peer Review: Is Testifying Worth the Hassle?*, MED. ECON., Aug. 20, 1984, at 168).

20. 42 U.S.C. § 11151(4)(A)(ii) (Supp. V 1987). The Act specifies health maintenance organizations and group medical practices as examples. Immunity is not available in those actions against health care practitioners other than physicians and dentists because "this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care." Hackney, The Health Care Quality Improvement Act of 1986 (16) (published by the American Bar Association in conjunction with its Forum on Health Law entitled Medical Staff and Hospitals: That Delicate Relationship) (October 5-6, 1989)(quoting H.R. REP. No. 903, 99th Cong. 2d Sess. 6, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6404 (Sept. 26, 1986)).

21. 42 U.S.C. § 11111(a)(1) (Supp. V 1987). Actions sounding in equity, such as actions for declaratory judgment or reinstatement, are not barred by this provision.

22. *Id.*

facts.[23] There is no immunity for actions that are based on something other than the physician's competence or professional conduct. Examples include: physician's membership (or lack thereof) in a professional organization, physician's fees or advertising, physician's involvement with prepaid group health plans, and participation in a particular class of health care practitioner.[24]

The HCQIA enumerates a number of procedures that boards must follow before the due process requirement is met. First, the review board must give the physician undergoing peer review notice of the proposed disciplinary action, the reasons supporting it, and at least thirty days to request a hearing.[25] If the physician requests a hearing, the reviewing body must then give the physician notice of the time, place, and date of the hearing, provided that it is no less than thirty days from the date of notice. The reviewing body must also supply a list of witnesses expected to testify.[26]

The board must hold the hearing, if one is requested, before an arbitrator who is mutually acceptable to both the physician and the health care entity, or before a hearing officer or panel of individuals who are appointed by the entity and who are not in direct economic competition with the physician involved.[27] This right to a hearing may be forfeited if the physician does not appear.[28]

At the hearing, the physician has the right to an attorney; to have a record of the proceedings; to call, examine, and cross-examine witnesses; to present evidence; and to submit a written statement at the close of the hearing.[29] Once the board has completed the hearing, the physician involved has the right to receive the written recommendation of the hearing officer, along with the basis for the recommendation, and to receive a written decision from the health care entity. It is important to note that a professional review body's failure to meet the conditions above does not necessarily mean that there were not adequate procedures.[30] There is an implication that if a health care entity follows its own bylaws or the statutory provisions of the state which are similar to those of the Act, it will have met the due process requirement.[31]

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23. *Id.* at § 11112(a)(1).
24. *Id.* at § 11151(9).
25. *Id.* at § 11112(b)(1).
26. *Id.* at § 11112(b)(2).
27. *Id.* at § 11112(b)(3)(A).
28. *Id.* at § 11112(b)(3)(B).
29. *Id.* at § 11112(b)(3)(C).
30. *Id.* at § 11112(b)(3)(D).
31. Rothschild, *Major Omnibus Health Package Becomes Law*, HEALTH L. VIGIL, Dec. 19, 1986, at 4.

Subchapter II of the Act authorizes the Secretary of Health and Human Services to create a national data bank which will collect information from health care providers and insurance companies via the state medical boards.[32] The purpose is to prevent the physician who has had privileges revoked in one hospital from relocating to another state and obtaining staff privileges in a hospital that is unaware of any prior disciplinary action. When a health care entity initiates a professional review action that results in the suspension or revocation of the physician's staff privileges for thirty days or more, or when a physician surrenders his privileges, the entity must report this information to the state board of medical examiners.[33] The board is then required to report this information, as well as the names of physicians whose licenses they have revoked, suspended, or restricted, and a description of the reasons for such actions, to the national practitioner data bank.[34] Failure of a health care entity to convey this information to the state medical board results in loss of the immunity given under the HCQIA for three years.[35] Failure of the state medical board to convey this information to the data bank will result in the Secretary's designation of another qualified entity to do the reporting.[36]

Insurance companies are also a part of the data bank and must report payments or partial payments on a policy in settlement of a malpractice action to both the medical board of examiners and to the data bank.[37] These insurers must report any payment, regardless of the amount.[38]

Beyond the obligation of health care providers to make reports to the data bank, they also have a duty to request information from the data bank on any potential new health care employee.[39] They also are obliged to make a biannual request of the status of all members of their health care staff.[40] No reporting is required until the data bank is operating, which is hoped to be sometime in mid-1990.[41]

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32. 42 U.S.C. §§ 11131, 11134 (Supp. V 1987).

33. *Id.* at § 11133(a)(1).

34. *Id.* at § 11132(a).

35. *Id.* at § 11133(c).

36. *Id.* at § 11132(b).

37. *Id.* at § 11131(a).

38. *See supra* note 32, at 5.

39. 42 U.S.C. § 11135(a)(1) (Supp. V 1987).

40. *Id.* at § 11135(a)(2).

41. *HHS Preparing to Implement Federal Medical Malpractice Data Bank Despite Lack of Funding*, THE BLUE SHEET, April 1988, at 8.

IV. THE RETURN OF *PATRICK V. BURGET*

Following the jury's tremendous award to Dr. Timothy Patrick, the Astoria Clinic and Drs. Boelling, Russell, and Harris appealed to the U.S. Court of Appeals for the Ninth Circuit. On September 30, 1986, the Appellate Court reversed the ruling of the lower court, stating that professional peer review which is conducted pursuant to state law is exempt from federal antitrust actions because this peer review is deemed to be "state action."[42]

Patrick petitioned for writ of certiorari and argued that the Ninth Circuit misapplied the doctrine of state action.[43] The issue he appealed to the Supreme Court was whether the peer review was conducted in "bad faith," and if so, whether the state action doctrine becomes inapplicable in that situation.[44] The American Hospital Association (AHA) filed an amicus curiae brief jointly with the American Medical Association (AMA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Oregon Association of Hospitals, and the Oregon Medical Association.[45] The amici agreed with the decision of the Ninth Circuit Court of Appeals and stressed the fact that protected peer review is necessary to improve the quality of health care. In the brief, they cited the Health Care Quality Improvement Act, which had been enacted just two months earlier, and requested that the Court not grant certiorari in the *Patrick* case, but wait until the HCQIA is in effect to make a ruling in a peer review antitrust case.[46] The Act is not retroactive, thus the doctors from the Astoria Clinic could not use it as a defense in the *Patrick* case.[47]

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42. Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986).

43. Rothschild, *AHA Files Amicus to Supreme Court in* Patrick, HEALTH L. VIGIL, Feb. 27, 1987, at 1.

44. *Id.* at 2.

45. *Id.* at 1. The AMA was formally organized in 1847 in order to promote the art and science of medicine. RAKICH, LONGEST, DARR, MANAGING HEALTH SERVICES ORGANIZATIONS (1985). One of the ways the AMA furthers its goals is through its political action committees which are "instrumental in having legislation enacted that preserves the integrity of health care." AMERICAN MEDICAL ASSOCIATION, HOW THE AMA WORKS FOR YOU (1988). The JCAHO is a nonprofit corporation which gives accreditation to those health care organizations that meet their standards for quality. Thirty-eight states (as of 1983), the Medicare program, and some Blue Cross plans rely on JCAHO accreditation. B. FURROW, S. JOHNSON, T. JOST, R. SCHWARTZ, HEALTH LAW 345 (1987).

46. *See supra* note 43, at 2.

47. 42 U.S.C. § 11111(c)(2)(C) (Supp. V 1987).

Despite the amici brief, the Supreme Court granted certiorari,[48] and on May 16, 1988, unanimously reversed the Ninth Circuit decision.[49] The Court found that in order for there to be protection of private parties under the "state action" antitrust doctrine, as the Ninth Circuit indicated, the "anticompetitive conduct 'must be actively supervised' by the State itself."[50] There is no active supervision of professional peer review in Oregon, as the state provides neither administrative nor judicial review with the ability to modify a review body's decision.[51] The implication of the Court's ruling is that immunity from federal antitrust suits for health care professionals and others involved in the peer review process did not exist before the HCQIA.[52]

V. THE EFFECT OF THE ACT

A. *The Immunity Provisions*

Some experts in medical circles have argued that the federal immunity from antitrust actions provided by the Act is not worth the procedures required to receive it. *Patrick* is the only case where a court has imposed antitrust liability upon physicians involved in the review of another physician's abilities.[53] Physicians have filed hundreds of antitrust suits after losing their clinical privileges or licenses, but have won none of them.[54] The result seen in *Patrick*, they claim, is unique due to the particularly egregious facts which make it obvious that the review was conducted in a malicious attempt to drive Dr. Patrick out of Astoria, Oregon.[55]

However, with the Supreme Court setting this precedent, antitrust liability for peer review board members certainly could have recurred.[56]

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48. Patrick v. Burget, 484 U.S. 814 (1987).

49. Patrick v. Burget, 486 U.S. 94 (1988), *reh'g denied*, 108 S. Ct. 2921, *on remand*, 852 F.2d 1241 (1988).

50. *Id.* at 100 (quoting California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) quoting Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)).

51. Christensen & Ellingsen, *Supreme Court Decides Patrick; Peer Review Alive and Well Despite Ruling*, HEALTH L. VIGIL, June 17, 1988, at 1.

52. *Id.*

53. Bierig, *Peer Review After* Patrick, 21 HOSP. LAW 135 (1988).

54. *Id.*

55. *Id.*

56. Positive effects of the Act are already beginning to be seen. A federal district court in California recently granted summary judgment for a hospital and its physicians who were active in the peer review process of one of their colleagues, Dr. Austin. The court found that the hospital had met the requirements for immunity under the HCQIA and was, therefore, protected from federal antitrust liability. Consequently, the physicians were also shielded from federal antitrust liability because § 11111(a)(1)(D) of the Act protects

The need for the federal grant of immunity conferred by HCQIA was tremendous against a *Patrick v. Burget* backdrop. Physicians for some time have been reluctant to serve on peer review committees and candidly evaluate their peers where there is even slight risk of liability.[57] By codifying this unspoken immunity, physicians have become more aware of the protection available to them, and can rely upon it.[58] This may be all the incentive that is needed to encourage quality peer review.

B. *The National Practitioner Data Bank*

Other criticisms of the HCQIA have to do with the national practitioner data bank. The data bank was supposed to be operational by November 14, 1987, but the necessary funds could not be generated. Finally, in June 1988, the House Appropriations Committee approved the Health and Human Services spending bill for fiscal 1989, and authorized initiation of the data bank.[59]

Originally, the AMA and the Federation of State Medical Boards (FSMB) submitted bids for the contract to operate the data bank. Each organization withdrew its bid upon realization that management of the data bank would require more resources than appeared at first glance.[60] UNISYS, an information systems company, was awarded the $15.9 million five-year contract, effective January 1, 1990, and given eight months to organize and implement the program.[61]

No one can deny the utility of the data bank in its attempt to stop negligent physicians from practicing medicine. The requirements set out

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"any person who participates with, or assists the body with respect to the [professional review] action." Austin v. McNamara, No. CV 88-04268 RG (C.D. Cal Feb. 20, 1990) (LEXIS, Genfed library, Dist. file).

57. Curran, *Legal Immunity for Medical Peer Review Programs: New Policies Explored*, 320 NEW ENG. J. OF MED. 233, 233 (1989).

58. It has been noted that the true benefit from HCQIA may be a psychological one. Holthaus, *Federal Law Offers Protection for Peer Review*, HOSPITALS, July 5, 1988, at 47.

59. *HRSA Targeted to Receive $796 Million*, THE BLUE SHEET, June 15, 1988, at 3.

60. Koska, *Hospitals on Hold for Data Bank Protocols*, HOSPITALS, Feb. 20, 1989, at 48. The AMA was willing to operate a clearinghouse for physicians and dentists but did not feel that it was feasible to include "dozens of diverse licensed health care practitioners, such as radiologic technologists and dieticians" as the HCQIA requires. *National Practitioner Data Bank Proposal Has Become Too Complex*, THE BLUE SHEET, August 17, 1988, at 6.

61. Koska, *Hospitals on Hold for Data Bank Protocols*, HOSPITALS, Feb. 20, 1989, at 48. *See also* Windom, *From the Assistant Secretary for Health*, 261 J. A.M.A. 1108, 1108 (1989). Although the data bank will not be operated by the Department of Health and Human Services, it will be monitored by the Federal Project Officer, a member of HHS' Office of Quality Assurance. Wilson, *New Information Resource, the National Practitioner Data Bank*, 104 PUB. HEALTH REP. 311, 311 (1989).

in the Data Bank Title IV Regulations not only clarify the provisions of the Act, but also broaden its scope. The regulations require reporting of adverse actions by health care entities, licensure actions by state medical boards, and malpractice payments made by any individual or entity on behalf of a physician, dentist, or any other health care practioner.[62] With regard to medical malpractice payments, it is noteworthy that no presumption of malpractice arises upon payment to settle a claim or action.[63]

Many physicians and other health care practitioners felt that the Act, as originally passed, was a conspiracy against their professional autonomy and a violation of procedural due process because they had no control over the information submitted to the data bank by the licensing board. To ease these apprehensions, the final regulations require the Secretary to "routinely mail a copy of any report filed in the Data Bank to the subject individual."[64] In order to dispute the accuracy of the reported information, the individual must notify the Secretary and the reporting entity, in writing. Until the discrepancy is resolved, reports on further requests for the same information will indicate its "disputed" status.[65] This procedure allows the affected individual an opportunity to "double check" reported information.

The regulations also place limits on who is able to obtain information from the data bank. Health care entities and state licensing boards inquiring about a particular physician, dentist, or other health care practitioner, and individual physicians, dentists, or other health care practitioners inquiring about themselves, can access the data.[66] Access is also available to those who are not interested in the identification of a specific health care entity, physician, dentist or other health care practitioner but want the information for other purposes.[67]

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62. National Practicioner Data Bank for Adverse Information on Physicians and Other Health Care Practicioners, 54 Fed. Reg. 42,730, 42,731-33 (1989) [hereinafter Data Bank Regs.] (to be codified at 45 C.F.R. § 60.5, .7-.9). "The Medicare and Medicaid Patient and Program Protection Act of 1987 (Section 5, Public Law 100-93) expands the bank's information base to include licensure disciplinary actions taken against all health practitioners and entities, such as hospitals or nursing homes, licensed by a state." Windom, *From the Assistant Secretary for Health*, 261 J. A.M.A. 1108, 1108 (1989).

63. Data Bank Regs., *supra* note 62, at 42,732 (to be codified at 45 C.F.R. § 60.7(d)).

64. *Id.* at 42,734 (to be codified at 45 C.F.R. § 60.14(a).

65. *Id.* (to be codified at 45 C.F.R. § 60.14(b)).

66. *Id.* at 42,733 (to be codified at 45 C.F.R. §§ 60.11(a)(1)-(4), (6). Malpractice insurance companies cannot access the data bank directly but can require physicians seeking coverage to provide data bank information as a prerequisite. Hudson & Koska, *The Data Bank: Final Regulations*, HOSPITALS, Dec. 5, 1989, at 35.

67. Data Bank Regs., *supra* note 62, at 42,733 (to be codified at 45 C.F.R. § 60.11(a)(7)).

Many health care professionals were concerned about the degree to which information in the data bank would be kept confidential. The way the HCQIA was originally drafted, plaintiffs' attorneys would have had access to the information in the data bank and peer review records would no longer be confidential.[68] Aware of this anxiety, the Regulations decline disclosure to attorneys unless they have filed a claim in state or federal court against a hospital and a particular practitioner, *and* it can be shown that the hospital failed to make its biannual data bank request of that practitioner. If those requirements are met, the attorney is permitted access to the data on the condition that the information be used solely in connection with litigation that results from the filing of the claim or action.[69] The information disclosed by the data bank is strictly confidential and can be used only for the purposes stated. Violation of this confidentiality is subject to a maximum $10,000 fine.[70]

Hospitals who at one time may have favored the Act are already trying to find ways to get around it because it places a large administrative burden upon them and adds to their expenses since they are responsible for the costs incurred by the data bank in the processing of the hospital's requests.[71] Although the actual fees for information requests have not yet been announced, this complaint carries little weight because all estimates by those involved indicate that fees will be in the range of three to five dollars per request.[72] The fees are to be based on actual cost of computer time, photocopying, and postage.[73] Admittedly, a large university hospital will incur greater costs than a small private hospital when the

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68. *Law Designed to Protect Peer Review Might Backfire*, 12 HOSP. PEER REV. 133, 133 (1987).

69. Data Bank Regs., *supra* note 62, at 42,733 (to be codified at 45 C.F.R. § 60.11(a)(5)).

70. *Id.* at 42,734 (to be codified at 45 C.F.R. § 60.13).

71. The hospitals must report all peer review committee decisions which adversely affect the clinical privileges of a physician for greater than 30 days to the data bank. To avoid the necessary compliance with HCQIA and the proposed regulations, it has been said that peer review committees will dole out 29-, rather than 30-day suspensions. *Law Designed to Protect Peer Review May Backfire*, *supra* note 68, at 135.

72. Hackney, *The Health Care Quality Improvement Act of 1986*, in MEDICAL STAFF AND HOSPITALS: THAT DELICATE RELATIONSHIP 42 (A.B.A. Forum on Health Law, Oct. 5-6, 1989). Hudson & Koska, *supra* note 66, at 33. No fee will be assessed a physician requesting information from the data bank regarding his or her own status. Windom, *supra* note 61, at 1108.

73. Data Bank Regs., *supra* note 62, at 42,733-34 (to be codified at 45 C.F.R. § 60.12(b)). The author is aware that the President's Budget for Fiscal Year 1990 makes a proposal that would require higher fees for requests so that the Data Bank could recover its operating costs, rather than the cost of processing only. If this proposal leads to a marked increase in access fees, then these higher hospital operating costs will, in the end, be passed on to the patient. Whether this is the proper party to bear the cost is certainly a debatable question. 54 Fed. Reg. 42,728 (1989).

biannual request is made, but the price is not too great considering that the immunity received under the Act will lead to enhanced peer review and decreased malpractice.

Hospitals are also worried that the Act will create tension between themselves and the state medical board. The medical board has authority to report to the Secretary any suspicions they have of a hospital that never reports malpractice claims or peer review actions.[74] With suspicions raised, the Secretary can conduct an investigation. If the Secretary finds that the hospital has failed to follow the reporting requirements, then the hospital will lose its immunity protection for three years.[75] Without immunity, there is concern that physicians will conduct peer review with less vigor or even refuse to participate in peer review altogether.[76] To avoid such an inquiry, a hospital will be more aggressive in evaluating the questionable behavior of its physicians.

VI. State Perspectives on the HCQIA

The federal immunity against antitrust actions provided in the HCQIA applies to all states. There was no immunity for physicians from *state* liability actions, however, until October 14, 1989, unless the state adopted legislation to opt in prior to that date.[77] If a state did not wish to be covered by the HCQIA's state immunity protection, then it was required to specifically opt out of the federal legislation.[78] There is some debate as to whether the Act preempts state immunity laws, although most commentators believe that there is no preemption. Nothing in the Act itself or in the legislative history indicates that preemption of state immunity laws was intended. Concerned, however, about a court's interpretation of the Act, some states, believing they had stronger immunities than given by the HCQIA, considered opting out of the Act's state im-

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74. *Law Designed to Protect Peer Review Might Backfire*, *supra* note 68, at 135 (1987).

75. 42 U.S.C. § 11111(b) (Supp. V 1987).

76. Holthaus, *The* Patrick *Case: Will it Hinder Peer Review?*, Hospitals, June 20, 1988, at 56. Note that physicians can only refuse to serve on peer review committees where it is not mandated by state law. *Id.*

77. 42 U.S.C. § 11111(c)(2)(A) (Supp. V 1987).

78. *Id.* at § 11111(c)(2)(B). All states had the option to adopt the HCQIA, or opt out by the October 1989 deadline. In order to opt out, a state needed to pass legislation that "waives immunity for peer review from lawsuits brought against them under state law." *HCQIA: CA Doctors Decide to Opt Out*, Hospitals, July 5, 1988, at 56 (quoting Howard L. Lang, M.D.).

munity provision.[79] California and Maryland were the only states to actually opt out of the HCQIA.[80]

Maryland opted out of the HCQIA because it believed that its Medical Practice Act[81] provided greater immunity to its hospitals and health care practitioners. The state did not want to be intertwined in the apparent confusion surrounding the HCQIA's state law immunities.[82] The state's opt out provision for physicians, dentists, and peer review bodies became effective on July 1, 1989.[83]

California opted out of the Act for fear of its possible misinterpretations and because it believed that it could provide stronger immunities for its participants in the peer review process.[84] Amended Senate Bill 1211, California's second attempt to opt out of the HCQIA, was unanimously supported by the Assembly and approved by the governor on September 8, 1989.[85] This statute requires more due process procedures than the federal legislation, including a more rigorous discovery process,[86] a right to engage in voir dire of any panel member or hearing officer,[87] a right to challenge the impartiality of the same,[88] a switch of the burden of proof from the review physician to the peer review board,[89] and the use of the preponderance of evidence standard.[90] The California legislature wanted to prevent unjustified accusations that could easily damage a physician's reputation, and felt that the best means for accomplishing this was through explicit and uniform due process procedures. The federal due process provisions are advisory and are to be used at the discretion of the hospital governing board,[91] but California's SB 1211

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79. Hackney, *supra* note 72, at 30.

80. A state is not permitted to opt out of the reporting requirements of Subchapter II of the Act.

81. *See* HEALTH OCC. CODE ANN. § 14-601(d), (f), 14-601.1 (Supp. 1989).

82. Address given by Virginia Hackney, ABA Forum on Health Law (Oct. 5, 1989).

83. MD. HEALTH OCC. CODE ANN. § 14-601.1 (Supp. 1989).

84. Address by Richard Robinson, ABA Forum on Health Law (Oct. 5, 1989). The fear of misinterpretation lies in the HCQIA's definition of "professional review body" as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity." 42 U.S.C. § 11151(11) (Supp. V 1987). The inference is that the Act authorizes the hospital governing board to perform peer review, when, in actuality, the medical staff is the only competent body to make decisions regarding a fellow physician's professional competence or professional conduct. Opting out based on this fear was for naught, however, because in the Final Regulations, this definition of professional review body was deleted.

85. CAL. BUS. & PROF. CODE § 809 (West Supp. 1990).

86. *Id.* § 809.2(d)-(f).

87. *Id.* at § 809.2(c).

88. *Id.*

89. *Id.* at § 809.3(b)(3).

90. *Id.*

91. *See* 42 U.S.C. §11112(b)(3) (Supp. V 1987).

requires that the minimum due process procedures set forth in the statute be incorporated into the bylaws of every hospital in the state.[92] There are those, however, who believe that the numerous extra procedures in the statute will increase the longevity of each peer review action, and physicians, having little spare time, will, therefore, be less willing to serve on these committees.[93] There is a fear among the opponents of the bill that the proceeding will focus less on the quality of health care and more on the correct legal procedures.[94]

Although the HCQIA has yet to be applied, it appears that Maryland and California's immunity provisions may not provide as much protection as the legislatures once thought. A recently decided Maryland case, *Sibley v. Lutheran Hospital*,[95] granted summary judgment on the physician's claim of defamation, but allowed the breach of contract claim against the hospital to go to trial. The hospital was not protected by its state immunity laws. The state's belief that its statute offered better protection proved to be incorrect. The result under the HCQIA may have been the same, but it certainly could not have been worse.[96]

VII. Additional Precautionary Measures

Since 1986, more than 100 bills have been passed in forty-four states which in some way reinforce programs designed to discipline physicians.[97] Examples of the new laws include requiring hospitals, doctors, and nurses to report any suspected unprofessional conduct or charges

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92. Cal. Bus. & Prof. Code § 809(a)(8) (West Supp. 1990).

93. Am. Med. News, Sept. 16, 1988, at 36, col. 3.

94. *Id.* The first bill to pass the California Assembly opting out of the immunity provisions of the HCQIA was vetoed by Governor Deukmejian on September 30, 1988. Governor Deukmejian's reason for vetoing SB 2565 was his concern that it would "take longer and be more costly for health facilities and peer review bodies to take actions against a licensee's staff privileges. This means an incompetent licensee [would] be practicing unrestricted that much longer, and it will be longer before a report is made to the appropriate licensing boards under [California law]." Am. Med. News, Oct. 21, 1988, at 3, col. 2. In actuality, this is not the case, as medical staffs would be able to temporarily suspend privileges of those physicians who are pending review. *Id.* at 34, col. 1. Possibly, Deukmejian was following the advice of the AMA which warned that before opting out, states should be sure that they have a "carefully tailored" system of immunity. *HCQIA: CA Doctors Decide to Opt Out*, *supra* note 78, at 56.

95. Sibley v. Lutheran Hosp. of Md., Inc., 709 F. Supp. 657 (D. Md. 1989), *aff'd*, 871 F.2d 479 (4th Cir. 1989).

96. Virginia Hackney, an authority in the area, believes that the HCQIA would have immunized the hospital from the breach of contract claim and furthered the intent of the Act: protection from liability in damage suits leading to more candid peer review. Hackney, *supra* note 72, at 11-12 n.36.

97. Wiebe, *Bad Medicine*, The New Physician, Jan./Feb. 1989, at 26 (citing to the Intergovernmental Health Policy Project in Washington, D.C.).

brought against physicians, and strengthening the licensing board's rules regarding physician discipline.[98]

In Texas, the state licensing board was given more investigatory power and must investigate any physician who has been sued three times in the last five years. The board can proceed against any physician convicted of criminal conduct before the appeals process has been completed, and is required to publicize any adverse actions taken against a physician.[99]

The state of Oregon has developed an original program which the state director of medical/legal affairs for the Oregon Medical Association hopes will be instituted throughout the country.[100] After the *Patrick* case, the Oregon Medical Association initiated a peer review system that works through the board of medical examiners (BME). When there is agreement among the physician being reviewed, the medical staff, and the hospital governing board that outside peer review is "in everyone's best interest," then they can request the board of medical examiners to assign an impartial group of physicians to conduct the peer review.[101] The BME is not given any of the details, thus the proceeding against the physician is kept confidential unless it is determined that disciplinary action will occur. The reviewing board is still obligated to follow that particular hospital's bylaws. If the reviewing board determines that disciplinary action is warranted, then to insure against accusations of antitrust violations, the BME must provide another group of physicians "to sit as finders of fact."[102] When a hearing is necessary, the BME can appoint an attorney as a hearing officer to conduct a "due process" hearing in compliance with the hospital's bylaws.[103] The second group of physicians, who were the finders of fact, give their conclusions to the hospital governing board, which then determines whether disciplinary action is actually necessary. At this time, the BME is notified of the governing board's action and given the details of the case.[104]

Oregon has also implemented a Risk Assessment and Management Program (RAMP) which is intended to avoid formal legal action altogether. "RAMP provides an alternative to litigation in situations in which the medical staff [believe] they need to take action on an individ-

98. *Id.*
99. *Id.*
100. Paul R. Frisch, director of medical/legal affairs for the Oregon Medical Association indicated that their program is unique to Oregon, but that he would like to see it implemented nationwide. *Strive to Augment Protections for Peer Review Activities*, 13 HOSP. PEER REV. 93, 94 (1988).
101. *New Statutes May Avert Huge Awards Against Peer Reviewers*, 13 HOSP. PEER REV. 65, 65 (1988).
102. *Id.* at 66.
103. *Id.*
104. *Id.*

ual's practice, but the physician doesn't think he or she can get a fair shake within the hospital."[105] Any hospital entity, medical staff, peer review committee, or even an individual physician can request the medical association to do a risk assessment of a physician on the staff, or the requesting physician.[106] The association sends physician experts to evaluate a doctor's practice, behavior, and malpractice claims.[107] Following the evaluation, the experts draft a contract which delineates the ways in which the physician's behavior and practice may be modified so as to reduce malpractice exposure.[108] The physician must agree to follow the requirements and sign the contract.[109] There has been a positive response to the program from hospital medical staffs and insurance carriers. As one commentator noted, the contracts convince them "that the specific criteria for success have been spelled out, that there is an educational program to help the physician achieve success, and that there is ongoing monitoring of the physician's activities."[110]

The state of Washington has also done something original. There was fear that under the federal legislation, peer review committees may have been given too much immunity. The state found it "necessary to balance carefully the rights of the consuming public who benefit by peer review with those who are occasionally hurt by peer review decisions."[111] When peer review is conducted on a basis other than professional competence, as in the *Patrick* case, then it is not conducted in good faith and the falsely accused physician is entitled to damages. The state statute provides for an "exclusive remedy" of "damages only for lost earnings directly attributable to the action taken by the professional review body [and] incurred between the date of such action and the date the action is functionally reversed."[112]

A new proposal in New York would require administering a test to each physician before recertification to determine if they still meet the medical standards. Currently, in order to be recertified, physicians need only return a form to the state government.[113] It is doubtful that this program will ever be implemented due to the costs involved to catch a

105. *Id.* at 67 (quoting Paul R. Frisch).
106. *Id.* at 67.
107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.* at 67-68.
112. *Id.* at 68. The purpose is to give a physician like Dr. Patrick an adequate remedy, "but not a goofy remedy," of $2.3 million. *Id.*
113. Wiebe, *supra* note 97, at 26.

small percentage of malpracticing physicians, but it is encouraging to see that steps are being taken.[114]

VIII. CONCLUSION

A jury award exceeding two million dollars to a physician who sued members of a medical peer review board shocked the medical community. Many physicians stopped serving as volunteers on the peer review committees; others, never having served, vowed never to do so. The reluctance of physicians to serve on peer evaluation committees is a serious problem. Like it or not, physicians are the only ones who have the expertise to know whether or not a fellow physician has committed medical malpractice. Peer review works as a policing system, separating the competent physicians from the incompetent. Without it, few malpracticing physicians will be sanctioned appropriately.

The Health Care Quality Improvement Act of 1986 augments the peer review system in two ways. First, it grants federal antitrust immunity to those physicians who conduct peer review. Second, the Act creates a national practitioner data bank for the accumulation of information regarding actions taken or sanctions imposed upon physicians, thus impeding the ability of these malpracticing physicians to transfer from state to state.

Ironically enough, the catalyst behind the Act, the case of *Patrick v. Burget*, could still occur despite the HCQIA. The outcome in the *Patrick* case was the result of peer review conducted specifically to drive Dr. Patrick out of business and out of town. If the same type of review were to happen today with the same motives, it would be in contravention of the Act's requirement that review be conducted in the furtherance of quality health care, and thus, there would be no immunity offered to the member of the reviewing organization.

Prior to the Act, if a peer review action was conducted in good faith, and without signs of anticompetitiveness, then an antitrust suit would not survive. The same holds true after the enactment of HCQIA. Disregarding peer evaluation conducted in bad faith, legislation was needed to assure medical staff personnel that they were protected from federal liability when fulfilling their ethical obligations. The HCQIA fills that niche.

The Health Care Quality Improvement Act is not the only safeguard needed to entice physicians to voluntarily serve on peer review committees. In order to fill in the missing spaces, experts recommend that peer review committee members do the following:

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114. *Id.*

(1) Develop alternatives to litigation.
(2) Lobby state legislators to expand protections and limit damages for peer review activities.
(3) Insist on indemnification for peer review responsibilities.
(4) Call in external peer reviewers to assist with difficult cases.
(5) Push Congress to augment protection under the [HCQIA].[115]

As far as developing alternatives to litigation, there are those who argue that neither a hearing nor an attorney is proper in the peer review evaluation process. Dr. Patrick's attorney thinks that a hearing before an arbitrator is a good idea and ensures the fairness of the proceeding. He believes that "[i]f there's reason to believe there's a rivalry between participants, they should get a neutral and impartial person to decide."[116]

The Act can also be seen as a method of alternative dispute resolution when one considers the potential advantages of a national practitioner data bank. The hospitals are already complaining about the extra administrative costs associated with the reporting requirements, but the benefits to be reaped are enormous. With effective peer review boards no longer under the threat of federal antitrust litigation, and with provisions in the Act requiring all hospitals to run a status check on all of their staff, current and incoming, the malpracticing physician might well become an extinct entity, or at least an endangered species. With a decreased number of malpracticing physicians, the number of harmful errors will be reduced, thereby abating the need for medical malpractice lawsuits. The less time and attention health care practitioners spend on litigation, the more time and attention they can spend with patients. As a result, patients will receive better care, feel more satisfaction in the care they receive, and therefore, be less inclined to seek redress in a court of law against a health care entity or practitioner. The Health Care Quality Improvement Act's attempt to improve the peer review process goes a long way toward furthering these goals.

Lynda M. Leedy

115. *Strive to Augment Protections for Peer Review Activities*, *supra* note 100, at 93.
116. Holthaus, *supra* note 10, at 56.